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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: ______

Last Name: ______ First: ______ Middle: ______

Age: ______ Date of Birth: ______ Sex: ______ Height: ______ Weight: ______

Referring Physician/Specialty: ______

CURRENT HEALTH CONCERNS; *Please list health concerns, symptoms and/or goals in their order of significance to you.*

1. ______
2. ______
3. ______
4. ______
5. ______

ONCOLOGY HISTORY

Initial Diagnosis/Tumor Type: ______ Date of Initial Diagnosis (Month/Year): ______

Any Subsequent Diagnosis/Metastasis: ______ Date: ______

______ Date: ______

Cancer Treatment:

Initial Therapy: ______ Date: ______

______ Date: ______

Secondary Therapy: ______ Date: ______

______ Date: ______

Additional Therapy: ______ Date: ______

______ Date: ______

______ Date: ______

☐ Other Therapies: ______ Date: ______

______ Date: ______

PERSONAL and FAMILY MEDICAL HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Autoimmune Disease									
Cancer *(Include Type)*									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches/ Migraines									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Osteoporosis									
Seizures									
Stroke									
Thyroid Disease									
Tuberculosis									

Any Serious Injury and/or Accident(s)?

Type:	Date:	Treatment:

PAST SURGICAL HISTORY; patient only

Please list surgical procedures and date; no need to repeat those listed above under the **Oncology History** *section*

Procedure	Date:

SOCIAL HISTORY and HEALTH HABITS

Current Residence (city, state): [ ] Occupation: [ ]

Domestic Status: ❑ Single ❑ Partnered ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do you have any **children**? ❑ Yes ❑ No

Age and gender(s): ______________________________

Do you use **tobacco** products? ❑ Yes; ❑ Presently ❑ Past – Years of Use: __________ ❑ No, never

Form and frequency: ______________________________

Do you use any **recreational drugs**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; __________) ❑ No, never

Form and frequency: ______________________________

Do you consume **alcohol**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; __________) ❑ No, never

Form and frequency: ______________________________

Do you have any special **dietary restrictions**? ❑ No ❑ Yes; ______________________________

How many servings of **vegetables** do you eat daily / weekly (½ cup)? __________

How many servings of **fruit** do you eat daily / weekly (piece or ½ cup)? __________

How many servings of **whole grains** do you eat daily / weekly (slice or ½ cup)? __________

Do you eat meat? ❑ No ❑ Yes; Fish? ❑ No ❑ Yes; Dairy? ❑ No ❑ Yes__________

How much **water** do you drink on a daily basis (glasses or ounces)? ______________________________

Do you drink **caffeine**? ❑ Yes; ❑ Presently ❑ Past (Quit Date; __________) ❑ No, never

Form and frequency: ______________________________

Do you use **exercise regularly**? ❑ No ❑ Yes;

Form and frequency: ______________________________

How many **hours of sleep** do you get each night on average? ______ Do you **wake rested**? ❑ No ❑ Yes

Do you have any **trouble falling asleep**? ❑ No ❑ Yes; Or **staying asleep**? ❑ No ❑ Yes;

If yes, please explain: ______________________________

Do you have any **significant work or home stress**? ❑ No ❑ Yes;

Please explain: ______________________________

Do you feel that you have adequate social support (family, friends, counselor, etc.)? ❑ No ❑ Yes

Do you have any notable current or past toxic exposure(s), either occupational or otherwise? ❑ No ❑ Yes;

Please explain: ______________________________

ALLERGIES

☐ Drug Allergy: [ ]

☐ Food Allergy: [ ]

☐ Environmental Allergy (mold, dust, hay fever, etc.): [ ]

CURRENT PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

Medication Name	Dose	Frequency	Reason for Prescription	Prescribing Physician	Start Date (mo/yr)

CURRENT SUPPLEMENTS

Product Name	Brand	Dose	Frequency	Reason	Prescribing Clinician	Start Date (mo/yr)

REVIEW OF SYMPTOMS; *please mark only current symptoms*

√	Constitutional	√	Gastrointestinal	√	Neurological
	Fatigue		Nausea		Dizziness
	Fever		Vomiting		Headache
	Chills		Constipation		Memory problems
	Night sweats		Diarrhea		Seizures
	Poor appetite		Gas/Bloating		Peripheral neuropathy
	Weight change		Indigestion/Heartburn		Muscle weakness
			Abdominal pain		Tremors
	Ears, Eyes, Nose & Throat		Blood/Mucous in the stool		
	Hair loss		Hemorrhoids		**Hematologic/Lymphatic**
	Changes in vision				Easy bleeding or bruising
	Eye pain		**Genitourinary**		Anemia
	Difficulty hearing		Painful urination		Swelling:
	Ear pain		Difficulty in urination		
	Ringing in ears		Frequent night urination		**Endocrine**
	Change in taste/smell		Blood in urine		Temperature intolerance
	Nasal discharge		Incontinence		Hair, skin or nail changes
	Nose bleeds		Urinary urgency		Altered thirst or hunger
	Throat pain/Sore throat		Urinary frequency		
	Difficulty swallowing		Sexual dysfunction		**Allergic/Immunologic**
			Poor libido		Autoimmune disease history
	Respiratory		Abnormal uterine bleeding		Immune deficiency
	Cough		Painful/Heavy menses		
	Shortness of breath				**Psychiatric**
	Wheezing		**Musculoskeletal:** *location*		Anxiety
			Muscle pain:		Depression
	Cardiovascular		Bone pain:		Irritability/mood changes
	Chest pain		Joint pain:		Sleep disturbance/insomnia
	Palpitations				
	Unusual ankle swelling		**Dermatological/Skin**		**Other:**
	Varicose veins		Rash		
			Eczema		
			Itching		
			Unusual spots/moles		

LABORATORY and EXAM HISTORY

Please provide date (month/year) and indicate any abnormal results for each of the following most recent tests

❑ Full physical exam: ________ ❑ Normal ❑ Other: ________
❑ Blood work: ________ ❑ Normal ❑ Other: ________
❑ Cholesterol: ________ ❑ Normal ❑ Other: ________
❑ Blood glucose: ________ ❑ Normal ❑ Other: ________
❑ Urinalysis: ________ ❑ Normal ❑ Other: ________
❑ Hemoccult/Blood in stool: ________ ❑ Normal ❑ Other: ________
❑ Colonoscopy: ________ ❑ Normal ❑ Other: ________
❑ DEXA/Bone scan: ________ ❑ Normal ❑ Other: ________
❑ Eye exam: ________ ❑ Normal ❑ Other: ________
❑ Dental exam: ________ ❑ Normal ❑ Other: ________

Women Only:

❑ Mammogram: ________ ❑ Normal ❑ Other: ________
❑ PAP/Pelvic exam: ________ ❑ Normal ❑ Other: ________

Men Only:

❑ Prostate Exam: ________ ❑ Normal ❑ Other: ________
❑ PSA: ________ ❑ Normal ❑ Other: ________

PHYSICIAN TEAM

Medical Oncologist

Providence Western Washington Oncology? ❑ Yes ❑ No

Physician Name: ________
Phone Number: ________
Fax Number: ________

Clinic/Facility Name: ________
Clinic Address: ________

Surgeon/Surgical Oncologist

Physician Name: ________
Phone Number: ________
Fax Number: ________

Clinic/Facility Name: ________
Clinic Address: ________

Radiation Oncologist

Radiant Care Radiation Oncology? ❑ Yes ❑ No

Physician Name: ________
Phone Number: ________
Fax Number: ________

Clinic/Facility Name: ________
Clinic Address: ________

Internal Medicine/General Care/Family Physician

Physician Name: ________
Phone Number: ________
Fax Number: ________

Clinic/Facility Name: ________
Clinic Address: ________